

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08361

08358

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL INSTITUTION OR STREET ADDRESS	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	MARYLAND COUNTY Maryland County Calvert (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH	
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Feb 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 41 yrs.
13. FATHER'S NAME Edgar Buck		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME Jeanie Howard
		17. INFORMANT & ADDRESS Jeanie Buck Husby, Md.	18. MEDICAL CERTIFICATION Ca of Cervix. Carcinoma
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 171X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Aug 31</u> , 1957, to <u>Aug 31</u> , 1957, that I last saw the deceased alive on <u>Aug 31</u> , 1957, and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>R. W. Ward</u> ADDRESS (Street, city, town, state) <u>5th Avenue</u> DATE SIGNED <u>9/3/57</u>			
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 8-3-57	NAME OF CEMETERY OR CREMATORIAL Eastern Chapel
24. REC'D BY REGISTRAR DATE 9-3-57		REGISTRAR'S SIGNATURE H. W. Ward	LOCATION (City, town, or county) Calvert Co. Md.
25. FUNERAL DIRECTOR'S SIGNATURE P. J. Sewell, Prince Fred, Md.		ADDRESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08359

## CERTIFICATE OF DEATH

08362  
51

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>	
3. NAME OF DECEASED (Type or print) <i>Isaac Edward Cox</i>		d. STREET ADDRESS	
4. DATE OF DEATH Month <i>Aug</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 28 1871</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years, lost birthday) yrs. <i>86</i>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co. Md.</i>		12. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
13. FATHER'S NAME <i>James Cox</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Tucker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Stanley Cox</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>GASTRIC HEMORRHAGE</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost. <i>151X</i>		DUE TO (b) <i>Pitillary Carcinoma of Stomach</i>	
DUE TO (c)		DUE TO <i>4KEROSINOSIS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>4KEROSINOSIS</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Plum Point</i> (County) <i>Calvert Co.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>19</i> , to <i>19</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Plum Point, Calvert Co. Md.</i> DATE SIGNED <i>8-2-57</i>			
ACTUAL SIGNATURE <i>Perry Jett</i>		M.D. <i>Perry Jett</i>	
PHYSICIAN'S NAME (Type) <i>PERRY C. JETT M.D.</i>		PRACTICE <i>Perry Jett</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 3, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Emmanuel Cemetery</i>		22d. LOCATION (City, town or county) <i>Plum Point</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness &amp; Son</i>		ADDRESS <i>Mutual, Md.</i>	
24a. RECD BY REGISTRAR <i>8-2-57</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

BUREAU V. S.  
RECEIVED  
MAY 5 1957

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION  
CERTIFICATE OF SERVICE

41

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08360

09311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN <i>W Beach</i> (If outside corporate limits, write RURAL and give nearest town)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <i>47x-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Grace</i> First <i>E</i> Middle <i>Wabstrom</i> Last		4. DATE OF DEATH <i>8 24 1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1910</i> 9. AGE (in years from birthday) <i>47</i> yrs. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during month of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>	
11. BIRTHPLACE (State or foreign country) <i>Wash DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>J. S. Shelly</i>		14. MOTHER'S MAIDEN NAME <i>Jeanna Eckloff</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Jane Costello 58050-1011</i>	
17. INFORMANT <i>Ward</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Stroke</i> DUE TO <i>Coronary disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Had several attacks</i>		20c. TIME OF INJURY Month, Day, Year <i>6/24 1957</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>House</i> 20f. (City or town) <i>Calvert</i> (County) <i>Calvert</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <i>8/24/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-28-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Wash Natl Cem</i>		22d. LOCATION (City, town, or county) <i>Saint Paul Rd - R. D. C. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas M. Idyong</i>		ADDRESS <i>13th &amp; N.W. Wash. D.C.</i>	
24a. REC'D BY REGISTRAR <i>8/24/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. W. Ward</i>	

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your records or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar or burier, or removal.

BUREAU U. S.

SEP 23 195

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08363

08361

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alabama</i>		c. LENGTH OF STAY IN 1b <i>3 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alabama</i>	
d. STREET ADDRESS <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jennie W. Duke</i>		First <i>Jennie</i>	Middle <i>W.</i>
4. DATE OF DEATH <i>Aug. 12 1957</i>		Month <i>Aug.</i>	Day <i>12</i>
5. SEX <i>F</i>		COLOR OR RACE <i>W</i>	6. DATE OF BIRTH <i>Apr. 14, 1868</i>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (in years last birthday) <i>89 yrs.</i>	
9. UNDER 1 YEAR IF UNDER 24 HRS. Months <i>3</i> Days <i>28</i> Hours <i>0</i> Min. <i>0</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Massachusetts</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Gardner Wadleigh</i>	
14. MOTHER'S MAIDEN NAME <i>Jane Carlile</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Caritas Kenny</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO <i>33IX</i>		Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cerebral Hemorrhage</i>	
DUE TO <i>—</i>		(c) <i>Hypertension</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1953</i> , to <i>Aug. 12</i> , 1957, that I last saw the deceased alive on <i>Aug. 12</i> , 1957, and that death occurred at <i>7:25 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>PAGE C. JETT</i>		ADDRESS (Street, city or town, state) <i>Pearce Frederick Md.</i>	
PHYSICIAN'S NAME (Type) <i>PAGE C. JETT</i>		DATE SIGNED <i>8/13/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>Aug. 15, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Calver Hill Crematory</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Q. H. Wadleigh &amp; Son Mutual, Inc.</i>		24a. REC'D BY REGISTRAR DATE <i>8-13-57</i>	
ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF DEFENSE - CALIFORNIA

CERTIFICATE OF SERVICE

RECEIVED

RECEIVED - DEPT. OF DEFENSE - CALIFORNIA

BUREAU V. S.

AUG 14 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Item 8 File No. 220 9-13-57 p+

**CERTIFICATE OF DEATH**

Reg. Dist. No. 51  
108364

1. PLACE OF DEATH a. COUNTY <b>Calvert</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsburgh</b>		d. STREET ADDRESS <b>5341 Fieldcrest Drive</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert Co., Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William</b>		First	Middle	Last	4. DATE OF DEATH <b>August 19 1957</b>	Month	Day	Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-1904</b>		9. AGE (In years from last birthday) <b>52</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Morris E. Feldman</b>		14. MOTHER'S MAIDEN NAME <b>Garnet Goldman</b>				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Phyllis Feldman Wife</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			19. INTERVAL BETWEEN ONSET AND DEATH <b>1/2 days</b>
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 39		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Huntingtown, Md</b>		(County) <b>Huntingtown</b> (State) <b>Md</b>	
21. I certify that I attended the deceased from <b>8/6</b> , 19 <b>57</b> to <b>8/7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8/6</b> , 19 <b>57</b> , and that death occurred at <b>Huntingtown, Md</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>G. J. Weems</b> PHYSICIAN'S NAME (Type) <b>Dr. George Weems</b>						ADDRESS (Street, city or town, state) <b>Huntingtown, Md</b>			DATE SIGNED <b>8/7/57</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 9, 1957</b>		22c. NAME OF CEMETERY OR CEMETORY <b>Slater Funeral Home</b>		22d. LOCATION (City, town, or county) <b>Pittsburgh, Pa</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. A. Frankness &amp; Sons - Mutual Ind</b>		24a. REC'D BY REGISTRAR DATE <b>8/8/57</b>				24b. REGISTRAR'S SIGNATURE <b>H. W. Ward</b>			

CERTIFICATE OF DEATH

RECEIVED  
Aug 12 1957  
Bureau W. A.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

118365  
51

Reg. Dist. No.

8363

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A1SME(5)  
5M 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Calvert</i> MARYLAND		a. STATE <i>MD</i>	b. COUNTY <i>Calvert</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Oliver</i>		<i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Harrison</i>
4. DATE OF DEATH		Month <i>Aug</i>	Day <i>3</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. UNDER 1 YEAR Months <i>67</i> yrs Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Petered</i>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>James Garner</i>		<i>Barbara Nichols</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
<i>410.1</i>		<i>217-05-3845 Ida M. Garner, Husby, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b),		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		22. ACTUAL SIGNATURE <i>John Harrison</i>	
NAME (Type)		DATE SIGNED <i>4 Aug 57</i>	
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL
<i>8-6-57</i>		<i>St. Johns</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <i>8-5-57</i>	24b. REGISTRAR'S SIGNATURE <i>N. W. Ward</i>
ADDRESS <i>Prince Frederick</i>			

1957

1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 08364 CERTIFICATE OF DEATH 08366  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelina</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelina</i>	
d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>LENORA B. MORSELL</i>		First <i>LENORA</i>	Middle <i>B.</i>
4. DATE OF DEATH Month <i>Aug.</i>	Day <i>10</i>	Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 25, 1878</i>
9. AGE (In years, months, days) <i>79 yrs. 5 mos. 15 days</i>		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <i>5</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
10c. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Cephas W. Bowen</i>		14. MOTHER'S MAIDEN NAME <i>Sally Skinner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-34-42</i>	
17. INFORMANT <i>John B. Morsell - Adelina, Grandson</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i>	
DUE TO <i>464X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. —		DUE TO <i>Popliteal Phlebitis</i>	
DUE TO <i>(b)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug. 12, 1957</i> to <i>Aug. 10, 1957</i> that I last saw the deceased alive on <i>Aug. 10, 1957</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. E. D. Judd</i>		DATE SIGNED <i>Prince Frederick</i>	
PHYSICIAN'S NAME (Type) <i>Paul C. Jr. 77</i>		ADDRESS <i>Prince Frederick, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 13, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Paul's Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Frederick, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness &amp; Son - Mutual, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>8-12-57</i>	
		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

RECEIVED

AUG 11 1960

BURDAU J. B. III

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08367

51

08365

## CERTIFICATE OF DEATH

Reg. Dist. No.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bolded copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-35 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Calvert</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Huntingtown</u>		MARYLAND LENGTH OF STAY (In this place) STATE <u>Maryland</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: <u>Huntingtown</u> STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS  00			
3. NAME OF DECEASED (Type or Print)  <u>Warren</u>		4. DATE (Month) (Day) (Year) (First) (Middle) (Last) <u>Parson</u> 8 1 1957	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE/MARRIED/ WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Faxman</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>James J. Parson</u>		14. MOTHER'S MAIDEN NAME <u>Christiana Ray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>611-8-53915</u>	
		17. INFORMANT & ADDRESS <u>Mildred Parson, Huntingtown Md</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  151X IMMEDIATE CAUSE (A) <u>Carcinoma of stomach.</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-1</u> , 19 <u>57</u> , to <u>8-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-1</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>G. Weenus</u> ADDRESS (Street, city, town, state) <u>Huntingtown, Md</u> DATE SIGNED <u>8/3/57</u> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>8-4-57</u>	NAME OF CEMETERY OR CREMATORIAL <u>St Edmunds</u> LOCATION (City, town, or county) (State) <u>Calvert Md</u>
24. REC'D BY REGISTRAR DATE <u>8-4-57</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>P. E. Sewell, Jr. Frederick Md</u>

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DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
 page 3 so it can be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08368

Item 2 File #220 9-11-57 pt  
**CERTIFICATE OF DEATH**

08368  
 51

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>39</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) "Rosehaven" (Mail to: North Beach, Calv. Co.) North Beach		d. STREET ADDRESS <b>02X2-2</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Susan</b>		First <b>A.</b>	Middle <b>Saunders</b>	Last <b>1</b>	4. DATE OF DEATH <b>8</b>	Month <b>8</b>	Day <b>31</b>	Year <b>1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/4/77</b>	9. AGE (In years last birthday) <b>80 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. MIN.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Homemaker, retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>Joseph Harding</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Graves</b>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Joseph Saunders, M. B. B. S. address</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>903.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>Age</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <b>Fall and fractured hip and dislocated shoulder</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>1130 p.m. July 23 1957</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was walking across floor and fell</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>July 23 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>North Beach, Md.</b>	(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>7/23</b> , 1957, to <b>8/31</b> , 1957, that I last saw the deceased alive on <b>8/31</b> , 1957, and that death occurred at <b>12:50 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>H. W. Ward</b>		ADDRESS (Street, city or town, state) <b>Owings, Maryland</b>		DATE SIGNED <b>8/31/57</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warren G. Humphrey</b>		ADDRESS <b>Silver Spring, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 3 1957</b>		24b. REGISTRAR'S SIGNATURE <b>H. W. Ward</b>						

COMMISSIONER OF RECORDS  
STATE OF HAWAII

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